Enrollment/Waiver Form
Qualifying Student Health Insurance Plan

All full-time and part-time students enrolled in a college, university or other institution of higher learning in Massachusetts must participate in a school sponsored health insurance plan, or another alternate plan with comparable coverage.

If you choose to participate in your school-sponsored program, place a check mark in the box next to: **Yes, enroll me in the School Student Health Insurance Plan.**

If you do not want to purchase the school sponsored insurance plan because you already have an alternate insurance plan comparable to the schools program, you must complete the enrollment/waiver form and submit it to your school before the deadline. Check your admission package for the deadline. If you do nothing, the school will automatically enroll you in the health plan and include the cost of the insurance in your tuition bill. It is very important that you comply with this requirement in order to avoid a charge for the insurance in your tuition bill.

If you have not received the enrollment/waiver form from your school, or have misplaced it, use the waiver form presented here. Although the form may not be identical to the enrollment/waiver form from your school, it contains the required information and your school will accept it.

NOTE: A new waiver form must be submitted for each academic year.

Enrollment/Waiver Form
Qualifying Student Health Insurance Plan

[_____[_____[_____
Student Name Social Security Number Date of Birth

[_____[_____[_____[_____[_____
Home Address Street City State Country ZIP Code

Please Check the Appropriate Box (es)

☐ **YES:** Enroll me in the _____ Student Health Insurance Plan.
Name of School

____ Individual Plan
____ Student and Spouse Plan
____ Student, Spouse and Children Plan

Signature_____[_____
Student (Parent or Guardian if student is under 18 years of age) Date

---

☐ **NO:** I do not wish to participate in the _____Student Health Insurance Plan
Name of the School

I certify that I have comparable coverage as indicated below.

Use the chart in Section B to check if your plan is comparable to the Qualifying Student Health Insurance Plan (QSHIP).

Section A: Health Insurance Information.
Please provide the following information about your health insurance:

[_____[_____[_____[_____[_____
Name of Insurance Company Street Address City State Phone #

[_____[_____[_____[_____[_____
Policyholder's Name SS# Policy Number Expiration Date Relationship to Student

[_____[_____[_____[_____
Name of Employer Street Address City State

Section B.

Type of Benefit	QSHIP Benefit	Your Plan s Benefit
Aggregate maximum benefit per accident or illness per policy year	$25,000	$
Inpatient Benefit		
Hospital Room and Board Expenses[semi-private room]	80% of the R&C Charges [R&C=Reasonable & Customary]	%
Intensive Care Unit Expenses	80% of the R&C Charges	%
Miscellaneous Hospital Expenses [Covered Medical expenses include, but not limited to, lab. tests, x-rays, anesthesia, supplies & equipment use, and medicines]	80% of the R&C Charges	%
Physician Hospital Visit Expenses	80% of the R&C Charges	%
Outpatient Benefit		
Maximum Covered Outpatient Medical Expenses	Payable up to a combined maximum of $1,500 per accident or sickness per policy year	$
Hospital emergency room visits that does not result in admission	80% of the R&C Charges after $100 co-payment.	%
Hospital emergency room visits by referral that does not result in admission	80% of the R&C Charges after $50 co-payment.	%
Hospital Outpatient Department Visits	80% of the R&C Charges after $50 co-payment	%
Physician Office Visits	80% of the R&C Charges after $25 co-payment	%
Specific Outpatient Procedures [including but not limited to C.A.T scan, M.R.I, Laser treatments]	80% of the R&C Charges up to a maximum of $2,000 after $200 deductibles	%
Surgical Benefits (Inpatient & Outpatient)		
Maximum benefit for each Surgical procedure	$5,000	$
Surgical Expenses	80% of the R& C Charges	%
Anesthetist and Assistant Surgeon Expenses	80% of the R& C Charges up to 30% of the maximum	%

Section B. (continued)

Type of Benefit	QSHIP Benefit	Your Plan s Benefit
Mental Health Benefit		
Inpatient Mental Health Expenses	Same as inpatient benefits for physical illness for a minimum of 60 days	?
Outpatient Mental Health Expenses	Same as outpatient benefits for physical illness for a minimum benefit of 24 visits	?
Ambulance Coverage		
Ambulance Expenses [Ground transportation]	Maximum benefit of $125 per accident or illness after $25 deductibles	?
Other Benefit		
Will your insurance pay for Emergency Care in the area where your school is Located?	Yes	Yes No
Does your plan have a primary Care Facility in the vicinity of the school that you are eligible to use when you are in school?	Yes	Yes No

I have determined that my insurance includes all benefits mandated by the Massachusetts Law. I have also determined that my insurance provides me access to health care providers in the area where my school is located.

I have read the above, understand it, and wish to waive enrollment in the _____Student Health Insurance Plan. I further certify that the information provided
Name of School
above is true and complete.

Signature_____[_____
Student (Parent or Guardian if student is under 18 years of age) Date